

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

NUVIGIL (armodafinil)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA:

- ▶ Pt. must be age 17 years or older

Covered for diagnosis:

- ▶ Narcolepsy- Amphetamines or Methylphenidate must be tried first. Dose limited to 250mg qd.
- ▶ Daytime somnolence due to Obstructive sleep apnea, **must be on C-pap**. Dose limited to 150mg qd.
- ▶ Shift Work Sleep Disorder, **must be working night shifts**. Provide documentation of a treatment plan that demonstrates excessive sleepiness at work, insomnia when the patient should be sleeping. Patient must have a three month trial of sleep aids. Dose limited to 150mg/day.

Authorization:

1 year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.

7/15/09